MDR Tracking Number: M4-03-5193-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 3/31/03.

I. DISPUTE

Whether there should be additional reimbursement for E1399 HC universal wrap and E1399 D0555 – NMS monthly supplies (batteries and electrodes), dated 9/25/02, reduced based on "F" –Medical Fee Guideline.

II. RATIONALE

Commission Rule 133.307 (g)(3)(D) states, " if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines);"

The 1996 Medical Fee Guideline, DME Ground Rules (IV) states, "This document does not contain a specific MAR for the DME items. The DME items should be billed at the usual and customary rate of the DME provider, and the insurance carrier shall reimburse the DME provider at an amount pre-negotiated between the provider and carrier or, if there is no pre-negotiated amount, the fair and reasonable rate for the item described. Use the miscellaneous HCPCS code, E1399 when no other HCPCS code is present for the DME or supplies provided to the injury worker…"

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
9/25/02	E1399-HC	139.90	118.90	F	DOP	Rule 133.307 (g)(3)(D) MFG, DME Ground Rules (IV)(C)	This DME. has no MAR. The requestor submitted several EOBs indicating other carriers recognize the requestor's billing rate as fair and reasonable. The carrier did not argue a "fair and reasonable" rate. On this basis, additional reimbursement of $20.98 is recommended.
	E1399 – D0555	85.00	72.25	F	DOP	Same as above.	A fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the 1991 Medical Fee Guideline. The "D" code for Stimulator Supplies is D0555.. Additional reimbursement of $12.75 is recommended.

TOTAL							The requestor is entitled to reimbursement of $33.73.

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for E1399 in the amount of **$33.73.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **$33.73** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 16th day of September, 2004.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb